Plastic surgery of the genital area

That this issue of JPRAS includes no less than 11 contributions on plastic surgery of the genital area in general and gender-confirming surgery in particular,[1–11] once again reflects the leading position of plastic surgeons in the development of these fields of interest. Our interest in the functional and psychological improvement of the genital area was obvious when the first volumes of major international plastic surgery journals were being published[12–17] and it has been given ample attention during our major international congresses. Because plastic surgery necessarily has a creative and innovating character this interest is mostly presented, as it is again in this issue of the JPRAS, as new or improved surgical techniques.[1–6] Once developed and introduced by plastic surgeons, such techniques are likely to be included in the surgical armamentarium of other specialists also. Still, merely developing or improving surgical options proves no longer to suffice. Increasingly, we are required to present a rationale for our deeds in light of both the financial limitations put forward by the health care insurance systems, and a responsibility to provide transparent information to commissioners and purchasers of health care about the benefits and disadvantages of surgery.[8, 9] We have the moral duty to provide not just *our* best of care, but *the* best of care to our patients.

Twenty-five years ago, Milton T Edgerton set the standards to provide the best of gender-confirming care.[18] These include: (1) a diagnostic selection process that will allow uniform screening of the many patients with gender dysphoria for those who may not be reasonably helped by gender-confirming surgery; (2) high-quality operations that give uniformly good aesthetic and functional results with reasonable cost and risk; and (3) careful postoperative follow-up of unselected groups of patients over a 10- to 20-year period.[18]

To address Edgerton's first standard, plastic surgeons necessarily lean on the expertise of specialised behaviour scientists,[19] and it has been agreed internationally that gender-confirming surgery should be provided only by dedicated specialists working in well-organised, multidisciplinary teams.[20] All current evidence presented by behaviour scientists supports the opinion that gender-confirming surgery is beneficial for well-selected patients and may be cost-beneficial for society.[20–23] Time and again, it has been proven that for the genuinely transsexual, ''cross-dressing is an insufficient help, as aspirin for a brain tumour headache would be.''[24]

Outcome studies such as those presented in this issue by Kim et al.[7] and Nelson et al.[8] and most of the work reviewed by Sutcliffe et al.[9] and Selvaggi and Monstrey,[10] support the conclusion that gender-confirming surgery provided by dedicated surgeons is of high quality and assures a favourable short-term aesthetic and functional outcome with restricted risk. Still, plastic surgeons tend to focus on reporting the innovations and refinements of technique to their peers in order to efficiently further the surgical treatment of as many patients as possible. These reports, by necessity, are concise and technically difficult to interpret for outsiders. This, indeed, limits the ability of commissioners of health care to identify studies that are relevant to them. To each of our patients we, obviously, have to explain the pros and cons of multiple gender-confirming surgical techniques so that he or she will be able to make a well-informed, individualised choice of treatment. The standard of care requires surgeons who are skilled in only a single technique, to so inform their patients and refer to another surgeon those who do not want, or are unsuitable for, this technique.[20]

So far, we failed to adequately address Edgerton's third standard even though long-term follow-up studies have increasingly been presented over the last years. Still, the level of evidence of these studies, in general, is poor as holds true for most of the plastic surgical literature and,[25, 26] indeed, most of the surgical literature.[26, 27] Notwithstanding the methodological and conceptual flaws of the evaluation of gender-confirming surgery presented in this issue,[28] its message is clear: we are in need of evidence of sufficient level to support the long-term benefits of these surgical interventions.[9]

Given that the life-long hormonal treatment of transsexuals is to be provided or, at least, supervised by gender teams,[20] this demand for long-term proof of adequate level is not irrational. It should be fairly easy to prospectively assess the long-term outcome of surgery as long as patients are being treated by other specialists of these multidisciplinary teams. Such assessment should not only address the anatomical or aesthetic outcome of surgery but also its functional and psycho-sociological implications. Only with such robust outcome data can we be expected to successfully counter the misconceptions or misinterpretations raised by outsiders regarding the magnitude of benefit and harm of our deeds.

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None

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Chief Editors comment: The Editorial which appears above by J. Joris Hage was written before the final issue was compiled and there are actually twenty-three articles related to genital and gender related surgery in the final issue.